The Hilltop Institute

analysis to advance the health of vulnerable populations

Market Rules and Adverse Selection

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Introduction

- The Affordable Care Act (ACA) is intended to reshape and standardize the public and private health insurance markets through a series of national and state regulations and programs.
- A system of Health Insurance Exchanges ("Exchanges") will serve as a new entry point to the individual and small-group health insurance markets for individuals who do not otherwise have coverage.
- The ACA establishes national standards that constrain what insurers can do when administering health insurance offerings and provides a framework—to shape how state Exchanges will function—that includes:
  - A minimum **essential benefit plan**
  - **A method for pricing insurance policies** using modified community rating
  - **Measures to moderate** the potential adverse impact of **selection effects** across insurance plans—reinsurance, risk corridors, and risk adjustment

Adverse Selection

- Adverse selection occurs whenever individuals make insurance purchasing decisions—based on their own perceived need for health services—that distort otherwise random insurance coverage risks.
- Insurers use a variety of mechanisms to mitigate against adverse selection, including underwriting, pricing, benefit design, network characteristics, and administrative rules.
- Adverse selection is of particular concern in the development of the Exchange system because of its potential to undermine the viability of Exchanges' operations.
- Maryland's Exchange Board—in concert with other policymakers such as the state Legislature and the Maryland Insurance Administration (MIA)—must identify the sources of adverse selection and consider what market rules are needed to mitigate its effects, including whether those rules should be the same inside and outside the Exchange.

Sources of Market Distortion: Benefit Design

- Direct competition among insurance carriers inside the Exchange may lead to adverse selection across insurance plans.
- To encourage favorable selection, carriers might use riders for special services (e.g., dental benefits), deductibles, and other aspects of benefit design, as well as provider network design.
- Federal rules that establish an essential benefit package and a tiered structure within which carriers must offer coverage are intended to moderate this source of selection effects to some extent, but carriers will still have considerable flexibility to influence their own enrollment in the absence of specific state guidelines.

Sources of Market Distortion: Market Selection Effects

- Benefit structure and network composition might also be used by carriers to influence whether individuals select coverage **inside or outside** the Exchange.
- Skewed selection effects may result if particular carriers are allowed to provide competing benefit plans selectively inside and outside the Exchange.
- If carriers are allowed to calculate premiums separately for plans offered inside and outside the Exchange, then selection effects may be exacerbated over time if higher-risk individuals tend to enroll inside or outside the Exchange.

Sources of Market Distortion: Timing and Participation

- If less-healthy individuals were to approach the Exchange first, a carrier entering the market later than other carriers would have an advantage to the extent that earlier issuers in the Exchange enroll a less-healthy cohort of individuals.
- In the absence of mitigating rules, such as requirements to offer some level of coverage within the Exchange in order to operate at all in the state, a carrier could establish a high-deductible, low-premium product designed to attract relatively healthy individuals.
- Attracting a relatively healthy mix of individuals with a high-deductible, low-premium product could lead to a relatively less-healthy population being covered through the Exchange, resulting in relatively higher premiums associated with the Exchange.

Sources of Market Distortion: Employer Behavior

- Self-insured employers might alter benefits, copayments and coinsurance options, premium contributions, and/or other factors in order to subtly encourage certain low-wage workers with high health risk to select the individual market in the Exchange, thereby lowering the employer's insurance costs.
- Small employers may discontinue support for coverage—or in some instances forgo establishing coverage—for all employees based on the availability of the Exchange as an option.

Sources of Market Distortion: Benefit Mandates

- Once the essential benefit package is defined by the U.S. Department of Health and Human Services (HHS), each state will need to consider what, if any, additional benefits will be required of health plans within the Exchange.
- Maryland has more than 60 separate mandates for health insurance plans and the state will need to consider whether to continue to mandate benefits that are not initially deemed essential.
- Federal regulations will require that the cost of mandated benefits above those initially deemed essential be borne by the Exchange. If the cost of such additional benefits are subsumed in the premium calculation used outside the Exchange, then the differing treatment of those costs inside and outside the Exchange may introduce another source of adverse selection bias.

The Health Insurance Market in Maryland

- Those who obtain health insurance coverage in Maryland do so through one of five products/sources:
  - Employer/group insurance products
  - Individual insurance products
  - Medicaid (including Children's Health Insurance Program (CHIP)
  - Medicare
  - Other public insurance programs
- Sixty percent of the state is covered through employer/group insurance products.
- More than half of that 60% is covered under self-insured health plans, which are not subject to state insurance laws or MIA oversight, and will be grandfathered under the ACA.
- About 13% of Marylanders are uninsured.

The Health Insurance Market in Maryland continued

Table 1. Health Insurance Coverage of the Maryland Population, by Type (2008-2009)

Coverage Type	Number of Individuals	% of Total Population
Employer/Group	**3,352,080**	**60%**
▪ Self-Insured Group	1,990,880	36%
▪ Insured Group	1,360,000	24%
Individual	**212,000**	**4%**
▪ Non-Association Plan	160,000	3%
▪ Association Plan	34,000	<1%
▪ MHIP	18,000	<1%
Medicaid	**571,100**	**10%**
Medicare	**611,700**	**11%**
Other Public	**59,500**	**1%**
Uninsured	**730,700**	**13%**
Maryland Total	**5,586,800**	**99%***

* Percentages do not sum to 100% due to rounding effects.

Sources: Kaiser Family Foundation, 2009; Milligan, 2010.

Related ACA Regulation

- While federal regulations regarding some key issues (such as the essential benefit package) remain to be finalized, recent guidance does outline a basic framework to mitigate whatever residual adverse selection effects will remain once basic operating rules for the Exchanges are established.
- That framework includes a combination of short-term measures that apply during the initial transition to Exchange operations in order to limit and share overall financial risk among carriers operating within the Exchange, as well as requirements for on-going risk adjustment of health program payments more broadly.

Related ACA Regulation: Reinsurance

- Reinsurance is a mechanism that insurers often use to limit their own risk in some way. An insurer can reinsure selected incidences of risk (e.g., high insurance claim costs for individual cases) or a book of business (e.g., total claim costs for an insurance product), and associated costs above a defined threshold dollar amount may or may not be shared between the insurer and the reinsurer.
- The reinsurance program established under the ACA will address individual high-cost cases in order to provide insurers with greater payment stability during the first three years of Exchange operations (2014-2016).
- The reinsurance program will be operated by each state with an Exchange. All health insurance issuers and third-party administrators on behalf of self-insured group health plans will make contributions to a nonprofit entity designated by the state to support reinsurance payments to individual market issuers that cover high-cost enrollee claims. States are afforded considerable flexibility in determining the details of the program beyond that basic structure.

Related ACA Regulation: Risk Corridors

- The risk corridor program is also conceived as a temporary way to share overall financial risk within the changing insurance market. However, in this case, the risk is defined relative to allowable costs at the health plan level, and that risk is shared between the federal government and qualified health plans.
- Between 2014 and 2016, HHS will administer the program whereby qualified health plans with costs that are at least 3% less than their projected allowable costs will remit charges to HHS for a percentage of those savings; qualified health plans with costs greater than 3% of their projected allowable costs will receive payments from HHS to offset a percentage of those losses.
- The states are not directly involved in the administration of this aspect of market reform, although both reinsurance and locally administered risk adjustment will be applied before consideration of the risk corridors.

Related ACA Regulation: Risk Adjustment

- Risk adjustment, in the context of the ACA, is a process through which health plan payments are adjusted for the actuarial risk of providing services.
- Health plan payments for non-grandfathered plans—both inside and outside the Exchange—will be adjusted on a budget-neutral basis to account for actuarial risk differences, and enrollment in covered plans will be treated as *one statewide risk pool*.
- HHS will establish criteria and methods for risk adjustment, likely to be analogous to diagnosis-based methods used under Medicare Advantage.
- States will be able to use qualified alternative methods and, although the ACA leaves open whether risk assessment will be administered at the federal, state, or health plan level, current guidance suggests that states should administer risk adjustment because of their role in collecting and distributing the payments across plans.
- Data requirements and methods of collection and administration need to be defined.

Summary

- The challenge for Maryland's Exchange Board will be to integrate competing local and federal interests and requirements to establish an Exchange that can support and sustain itself financially.
- Administrative procedures (e.g., reinsurance and risk adjustment) are needed to moderate the risk of operating inside and outside the Exchange.
- This needs to be accomplished while simultaneously ensuring the availability of an insurance provider network that meets the public and private health needs in the state—and doing so within a uniquely Maryland context.

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

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